calculations. This bonus amount is calculated as follows: (10% of the target increase * the lower of 2002 CNA hours or 2000 CNA hours).
b. In addition, providers that had fewer 2002 CNA hours and/or more Medicaid days in 2002 may spend any additional revenue as a permissible bonus. This creates a situation where the actual target increase is greater than the estimated target increase. The amount of this permissible bonus is determined as follows: ((Actual target increase – estimated target increase) * CNA rate year hours)).

7. The Division will determine whether the Provider has spent the add-on revenue on 2002 Average Hourly Wage Increases, or where applicable, permissible bonuses. The recovery amount will be the difference between the Add-on Revenue received and the total wage increase given, determined as follows:

Revenue received = (per diem add-on * 2002 Medicaid days)

Total increase given =
((2002 Average Hourly Wage Increase) * lower of annualized base period CNA regular and overtime hours or 2002 CNA regular and overtime hours) + permissible bonus (if given)

8. The Division and/or the Division of Medical Assistance may conduct audits to verify amounts reported by the facility.

(e) Recoupment Payments to CNAs. Providers must pay 150% of the recovery amount calculated pursuant to 114.2 CMR 6.06(1)(d) to the Certified Nurses' Aides employed at that facility at any time during calendar year 2002. The facility must make this payment to the CNAs within one month from the notification of the recovery.

1. The facility must calculate a payment amount to be paid to the CNAs based on the total hours worked for the entire calendar year. Any CNA that worked in the facility during calendar year 2002 is entitled to a payment. The facility must sum the total 2002 hours worked by all CNAs in the facility. The payment amount for each CNA will equal (hours worked by the individual CNA / total hours worked by all CNAs in 2002) * 150% of the recovery amount. The facility must run a special payroll distribution to make the payments to the CNAs.
2. The facility must provide a copy of the calculation of the distribution to the Division. The facility must also provide a copy of the payroll run to the Division within one month from the notification of the recovery.
3. The Division may audit the payroll register of the facility or request additional documentation from the facility to support the distribution of payments.

(f) 2003 CNA Add-on Recovery. The Division will implement a CNA Add-on recovery for Calendar Year 2003 pursuant to the methodology prescribed in 114.1 CMR 6.06(1)(b) - (e).

(2) Retroactive Adjustments. The Division will retroactively adjust payments in the following situations:

(a) Mechanical Errors. The Division may adjust payments if it learns that there is a material error in the rate calculations.

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(b) Errors in the Cost Reports. The Division may adjust payments if it learns that the Provider has made a material error in the cost report.

(3) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the Division of Medical Assistance, or a Provider's payments include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(4) Residential Care Beds. The Division will establish separate Nursing and Other Operating Costs payments for Residential Care Beds in a dually-licensed facility. The Division will determine the proportion of 2000 reported costs allocable to the rest home beds. Administration and General Costs will be based on 2000 costs, subject to a cap of $12.73. It will exclude from the calculation reported costs for Ward Clerk, Utilization Review, Medical Records, and Advisory Physician. Allowable costs will be adjusted by a Cost Adjustment Factor of 5.96 percent and will be limited to the 2002 freestanding rest home ceiling established in 114.2 CMR 4.00. Nursing costs will be reduced by CNA add-on revenue received in 2000. The facility's payment for Residential Care Beds will not exceed its Payment for Payment Group H Nursing Facility Residents.

(5) Reopened Beds Out of Service. Providers with licensed beds that were out of service prior to 2002 that reopen in 2002 will receive the lower of the Standard Payments or the most recent prior payments inflated to 2002 for Nursing and Other Operating Costs.

(6) Pediatric Nursing Homes. Payments to facilities licensed to provide pediatric nursing facility services will be determined using 2000 Allowable Reported Costs for Nursing and Other Operating Costs, excluding Administration and General Costs, adjusted by a Cost Adjustment Factor of 5.96 percent.. Administration and General Costs will be based on 2000 costs, subject to a cap of $12.73. Nursing costs will be reduced by CNA add-on revenue received in 2000. A pediatric nursing facility may apply to the Division for a payment adjustment for the otherwise unrecognized medical costs of residents over the age of 22 who were previously enrolled in the facility's Chapter 766 program. The Division will calculate an adjustment to include the reasonable costs for these services subject to approval by the Division of Medical Assistance.

(7) Payments for Innovative and Special Programs.

The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

1. The Provider has received prior written approval from the Executive Office of Elder Affairs to establish and maintain a program; or
2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

(8) Receiverships. The Division may adjust the rate of a receiver appointed under M.G.L. c. 111, s. 72N solely to reflect the reasonable costs, as determined by the Division and Division of Medical Assistance, associated with the court-approved closure of the facility.

6.07 Reporting Requirements

(1)Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete

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financial condition of the Provider, including all applicable management company, central office, and real estate expenses.
(b) Realty Company Cost Report.. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.
(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(d) Nursing Expense Reports. A Provider must file a 2002 Year-End Nursing Expense Report with the Division by February 15, 2002.

(e) Financial Statements. If a Provider or its parent organization is required or elects to obtain independent audited financial statements for purposes other than 114.2 CMR 6.00, the provider must file a complete copy of its audited Financial Statements that most closely correspond to the provider's Nursing Facility Cost Report fiscal period. If the provider or its parent organization does not obtain audited Financial Statements but is required or elects to obtain reviewed or compiled Financial Statements for purposes other than 114.2 CMR 6.00, the provider must file a complete copy of its Financial Statements that most closely correspond to the Nursing Facility Cost Report fiscal period. Financial Statements must accompany the provider's Nursing Facility Cost Report filing. Nothing in this section shall be construed as an additional requirement that nursing homes complete audited, reviewed, or compiled Financial Statements solely to comply with the Division's reporting requirements.

(f) Collective Bargaining Agreements for CNAs. If a Provider has a collective bargaining agreement in effect with any or all CNAs employed by the facility between the period April 1, 2000 and December 31, 2002, it must provide to the Division copies of any collective bargaining contracts and the applicable CNA wage schedules that are or were in effect during that period. Facilities will be required to identify the total wage and payroll tax amounts that are attributable to the collective bargaining agreements.

(2) General Cost Reporting Requirements
(a) Accrual Method Providers must complete all required reports using the accrual method of accounting.
(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.

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(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.
(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions that the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.
(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:
   a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;
   b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and
   c. Expenses related to policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.
   d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.
   e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.
2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.
3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.
4. Fixed Costs.
   a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.
   b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.
   c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

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d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment , accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.

6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.

8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.

b. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.

c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.

b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided

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Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, that clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first Notification of Change in Beds.

2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will allocate fixed Equipment on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures that relate to the total plant on a square footage basis.

d. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics used in preparing the Nursing Provider Cost Report.

(3) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) The cost adheres to the Prudent Buyer Concept;

(c) Payments to related parties: Expenses otherwise allowable shall not be included for purposes of determining rates under 114.2 CMR 6.00 where such expenses are paid to a Related Party unless the provider identifies any such Related party and expenses attributable to it in the Reports submitted under 114.2 CMR 6.00 and demonstrates that such expenses do not exceed the lower of the cost to the Related Party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the Related Party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

(d) Employee Benefits: Only the provider's contribution of Generally Available Employee Benefits shall be deemed an allowable cost. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer. To qualify as a Generally Available Employee Benefit, the provider must establish and maintain evidence of its nondiscriminatory nature. Generally Available Employee Benefits shall include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. Bonuses related to profit, private occupancy, or directly or indirectly to rates of reimbursement shall not be included for calculation of prospective rates. Benefits which are related to salaries shall be limited to allowable salaries. Benefits, including pensions, related to non-administrative and non-nursing personnel will be part of the other operating cost center. Benefits that are related to the Director of Nurses, including pensions and education, shall be part of the Nursing Cost Center. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken, provided that these benefits are both stated in the written policy and are the actual practice of the provider and that such benefits are guaranteed to the employee even upon death or termination of employment. Such expenses may be recorded and claimed for reimbursement purposes only as of the date that a legal liability has been established.

(e) The cost must be for goods or services actually provided in the nursing facility; and

(f) The cost must be reasonable; and

(g) The cost must actually be paid by the Provider. Costs not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs discharged in bankruptcy; costs forgiven; costs converted to a promissory note; and accruals of self-insured costs based on actuarial estimates;
(h) A provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;
2 Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
3. Expenses not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
4. Compensation and fringe benefits of residents on a Provider's payroll;
5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies not registered with the Department under regulation 105 CMR 157.000 or paid for at rates greater than the rates established by the Division pursuant to 114.3 CMR 45.00;
8. Any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the facility;
9. All legal expenses, including those accounting expenses and filing fees associated with any appeal process;
10. Prescribed legend drugs for individual patients;
11. Recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than residents, telephone income, vending machine income and medical records income. Vending machine income shall be recovered against Other Operating Costs. Other recoverable income shall be recovered against an account in the appropriate cost group category, such as Administrative and General Costs, Other Operating Costs, Nursing Costs, and Capital Costs. The cost associated with laundry income which is generated from special services rendered to private patients shall be identified and eliminated from claims for reimbursement. Special services are those services not rendered to all patients (e.g., dry cleaning, etc.). In the event that the cost of special services cannot be determined, laundry income shall be recovered against laundry expense.
12. Costs of ancillary services required by 114.2 CMR 6.00 or by a governmental unit to be billed on a direct basis to the purchasing government unit;
13. Accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, shall not be included in the prospective rates. When the Division receives satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates.

(4) Filing Deadlines.

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(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.
2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.
3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
4. Termination of Provider Contract. If a Provider contract between the Provider and the Division of Medical Assistance is terminated, the Provider must file Cost Reports covering the current reporting period or portion thereof covered by the contract within 60 days of termination.
5. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Division may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances that prevent the Provider from meeting the deadline; and
3. file the request with the Health Data Policy Group at the Division of Health Care Finance and Policy no later than 30 calendar days before the due date.

(5) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information that the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Audits. The Division and the Division of Medical Assistance may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(7) Penalties. If a Provider does not file the required Cost Reports by the due date, the Division may reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

6.08 Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with

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the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal .

(3) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 6.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 6.00: M.G.L. c. 118G.

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Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

MassHealth
Nursing Facility Bulletin 115
August 1998

TO: Nursing Facilities Participating in MassHealth

FROM: Bruce M. Bullen, Commissioner

RE: **Voluntary Ancillary Pilot Project**

Introduction

The Division is conducting a voluntary pilot project. The project will study the inclusion of ancillary goods and services in nursing-facility per diem rates. The purpose of this bulletin is to describe how the voluntary ancillary pilot will be conducted.

Informational Sessions

The Division of Medical Assistance, in collaboration with the Division of Health Care Finance and Policy and the Massachusetts Extended Care Federation (MECF), will be holding three statewide informational meetings. **Please contact MECF at (617) 558-0202 to register for one of the following sessions and for directions.**

Tuesday, August 25, 1998 *10:00 a.m. to 12:00 p.m.*	*Willows at Westborough,* *1 Lyman St.* *Westborough, MA*
Wednesday, August 26, 1998 *10:00 a.m. to 12:00 p.m.*	*Mass. Extended Care Federation* *2310 Washington St.* *Newton Lower Falls, MA*
Thursday, August 27, 1998 *10:00 a.m. to 12:00 p.m.*	*Elihu White Nursing and Rehab. Ctr.* *95 Commercial St.* *Braintree, MA.*

Objectives

The main objectives of the voluntary pilot project are to:

1. collect information to enhance the Division's understanding of how best to include ancillary goods and services into fully bundled nursing facility rates; and
2. assess what accommodations may be needed to ensure access to adequate and appropriate service levels for MassHealth members.

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Overview

The ancillary pilot project will:

1. determine for each participating facility a per diem Medicaid ancillary cost per day based on state fiscal year (SFY) 1996 ancillary claims payments, inflated for the pilot period during SFY 1999. Throughout the remainder of this bulletin this amount will be referred to as the facility specific rate (FSR);
2. utilize a statewide standard payment per day for ancillary goods and services. The statewide standard payment per day (SSPD) equals $5.85;
3. pay a participating facility based on a risk/return model (Risk/return sharing between the facility and the Division will be in the form of a retrospective settlement considering the prospective ancillary allowance and the actual amount expended by the Division in payments to ancillary vendors.);
4. exclude from retrospective settlement calculation any patient with ancillary spending per patient day in excess of 500% of the statewide-average ancillary-per-diem payment for the period of the pilot project;
5. reconcile each facility's final payments at the end of the pilot project;
6. allow ancillary vendors to continue to bill the Division directly; and
7. make available for each participating facility monthly updates on ancillary spending.

Payment

A facility chosen to participate in the pilot project will be assigned to one of two payment groups depending on their FSR. (Please refer to Attachment A to determine the payment model for your facility) The groups are as follows:

1. Group I, Standard Payment Model: A facility will be assigned to this group if their FSR falls between the statewide standard of $5.85 and $7.02 (120% of $5.85).
2. Group II, Outlier Payment Model: A facility will be assigned to this group if their FSR falls either between $1.17 (20% of $5.85) and $5.85 or between $7.02 (120% of $5.85) and $11.70 (200% of $ 5.85). Facilities with spending levels less than $1.17 or greater than $11.70 are excluded from participation in the pilot project.

Billing

For administrative simplicity, vendors of ancillary goods and services will continue to submit claims to the Division directly, and the Division will continue to process these claims for payment.

Final Settlement, Group I

There is no financial risk for facilities participating in this group. The baseline amount for this group is the statewide standard per diem of $5.85. Settlements at the end of the pilot period will be based on: payments to vendors during the pilot; the statewide standard per diem ($5.85); and the facility specific rate (FSR). The methods for settlement will be:

1. if vendor payments are less than the FSR but are greater than $5.85 (SSPD), the Division will pay the facility 25% of the difference between their FSR and actual vendor payments; or
2. if vendor payments are less than $5.85 (SSPD), the Division will pay:
   a. the amount calculated in (1) above, plus 50% of the difference between $5.85 and the actual vendor payments up to $2.93 (50% of $5.85); or
   b. if vendor payments exceed the FSR there will be no settlement with the facility.

Final Settlement, Group II

The baseline amount for this group is the amount equal to the facility specific rate (FSR). Final settlement will be based on the difference between vendor payments and the baseline amount (FSR). The methods for settlements will be:

1. if vendor payments are less than the FSR, down to and including 50% of that amount, the Division will pay the facility an amount equal to 50% of the difference; or
2. if vendor payments exceed the FSR, up to and including 150% of that amount, then the facility will reimburse the Division for 25% of the difference between that amount and the actual vendor payments.

Reconciliation and settlement through this approach effectively cap both the downside and upside financial exposure for facilities. Risk is capped at 12.5% of the FSR. Return is capped at 25% of the FSR.

Special Conditions

For ancillaries that are provided by the facility itself there will be no payment to the facility or to special vendors. These are services the facility decides to make rather than buy or to make special contracts with vendors for fees below levels in the MassHealth rate schedule. These amounts will not be considered part of the incurred vendor payments. This means that the facility and the Division will share in the reduction of vendor payments that may result from such arrangements. For these situations the facility will:

1. notify the Division (Lisa McDowell) in writing of the changes being made and the affected services; and
2. segregate the costs incurred in providing the goods and services.

Settlement examples and grids for both groups can be found in Attachments B and B1.

Timing and Duration

The pilot project will run from October 1, 1998, through June 30, 1999. The project sample will constitute those residents in the facility on October 1, 1998, and those admitted to the facility between October 1, 1998, and March 31, 1999. The data collection period will run from October 1, 1998, through June 30, 1999, allowing all residents to be tracked for the duration of their stay or for three months, whichever is shorter. The final evaluation activity will occur from July 1, 1999, to September 30, 1999.

Evaluation Protocols

The evaluation will rely on facility pre- and post-pilot comparisons and comparisons with all nonparticipating facilities. The intent is to describe outcomes and issues of the administrative feasibility of bundled payment. The issues that will be examined include changes and/or differences in:

1. MassHealth payments for ancillaries, and for all health care taken together for patients served under the participating groups;
2. prescribing patterns and frequency of key, necessary therapies and pharmaceuticals, and the appropriateness of this care (including treatment for secondary conditions);
3. frequency and patterns of admission for persons with high ancillary costs or heavy care needs; and
4. corroborating evidence of changes in clinical and administrative decision making.

Evaluation Data Needs

Several types of data will be needed to answer the evaluation questions. These data include the following.

1. Medical records data.
2. MDS/MMQ data.
3. Claims and payment data for study patients. (Claims data in the baseline and post period will be provided by the Division.)
4. Qualitative management information — intensive case studies at 10-12 facilities. (These administrative studies will require two or three site visits each in order to document the changes in clinical and administrative decision making regarding ancillaries and the nature of in-house controls and physician interactions. It is also likely that the qualitative data collection will include focus groups or direct interviewing of persons conducting discharge planning in selected hospitals to determine if there are patterns of restricted access (difficult placement) for certain types patients in pilot facilities.)
5. Tracer conditions – selected conditions where pilot effects are expected to be most pronounced or most interesting.

Selection Criteria

The selection of facilities to participate in the pilot project will be determined by the Division. At a minimum, facilities must meet the following criteria in order to be considered for participation in the pilot project.

1. Capacity of 60 or greater beds.
2. Facility-specific ancillary costs per patient day between $1.17 and $11.70 (See Attachment C).
3. No significant changes in facility operations since 1996 including, but not limited to: mission, licensure, and casemix.
4. No substandard quality of care issues identified by the Department of Public Health that may impact participation and/or outcomes of the study.

Obligations of Participants

Facilities that are selected to participate will agree to:

1. remain in the pilot for the duration of the project;
2. provide all necessary data including MDS on patients;
3. provide access for medical-record reviews;
4. allow interviews and observation by evaluators;
5. notify the Division of special arrangements for ancillaries; and
6. retain associated cost information.

Applications

Facilities that meet the minimum participation requirements and that are interested in applying should complete the Application Form found in Attachment D. The deadline for the receipt of applications is August 31, 1998. Send your applications to:

Lisa McDowell
Division of Medical Assistance
600 Washington St.
Boston, MA 02111